UNITED STATES BANKRUPTCY COURT
EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

In re:

City of Detroit, Michigan,

Debtor.

_____/

Bankruptcy Case No. 13-53846
Honorable Thomas J. Tucker
Chapter 9

EXHIBIT E (HAP PLAN) IN SUPPORT OF DPLSA'S RESPONSE IN OPPOSITION TO CITY OF DETROIT'S MOTION FOR (I) DETERMINATION THAT THE DETROIT POLICE LIEUTENANTS AND SERGEANTS ASSOCIATION HAS VIOLATED THE TERMS OF THE CITY OF DETROIT'S CONFIRMED PLAN OF ADJUSTMENT AND THE ORDER CONFIRMING IT; AND (II) ORDER (A) ENJOINING FURTHER VIOLATIONS AND (B) REQUIRING DISMISSAL OF STATE ACTIONS [DOCKET NO. 9656]

PART 3 OF 5

HMO
Health Maintenance Organization

Health Alliance Plan of Michigan

Subscriber Contract

Health Alliance Plan of Michigan (HAP) hereby certifies that individuals eligible for insurance are insured under the above Contract as determined by the provisions contained in Section 2 of this Contract. The Contract details the benefits and terms of coverage. You are entitled to the benefits described in the Contract in exchange for the Premium paid to HAP.

The benefits available under this Policy will be administered consistent with the requirements of state and federal law, including but not limited to the Affordable Care Act (ACA), as such provisions may be implemented over time in accordance with the legislation. Groups that qualify as grandfathered as that term is defined in ACA may be eligible for a different Schedule of Benefits than non-grandfathered groups. Groups shall self-identify as a grandfathered group, if such status applies

James Connelly
President and CEO, Health Alliance Plan
Executive Vice President, Henry Ford Health System

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HEALTH ALLIANCE PLAN
HMO SUBSCRIBER CONTRACT

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HEALTH ALLIANCE PLAN

HMO SUBSCRIBER CONTRACT

SECTION 1—INTRODUCTION

1.1 Your Coverage

You and your eligible Dependents are entitled to receive the benefits described in this Contract pursuant to an agreement between your Group and HAP. You may also have Riders and a Schedule of Benefits. Your Riders and Schedule of Benefits change the benefits and Eligibility rules described in this Contract. You should keep this Contract, Riders and Schedule of Benefits with your other important papers so that they are available for your future reference.

1.2 HMO Coverage

This Contract provides coverage through Health Alliance Plan (HAP), a nonprofit corporation licensed by the State of Michigan as a Health Maintenance Organization (HMO). Because HAP is an HMO, the services covered under this Contract must be provided, arranged or authorized in advance by your Personal Care Physician (PCP). Your PCP is an Affiliated Provider that you choose who is primarily responsible for providing or arranging for health care services for you. In some cases, your PCP will also need to have services approved by us. Because your PCP is the key to receiving services under this Contract, make an appointment to see your PCP soon. It is also important to read this Contract carefully before you need services.

1.3 This Contract

This Contract is an agreement between HAP and persons who have enrolled as Members. It contains important information about your coverage. You should read this Contract carefully before you need services. By enrolling in HAP and accepting this Contract, you agree to abide by this Contract and recognize that HAP is responsible for arranging, paying or reimbursing for only those services and benefits that are Covered Services under this Contract, subject to all exclusions and limitations set forth herein.

1.4 Definitions

Throughout this Contract, Health Alliance Plan is referred to as "we", "us", "our" or "HAP". The words "you", "your", "yours" or "Member" refer to the Subscriber and/or any Dependents covered under this Contract. There are other words, phrases, and commonly used definitions of health coverage and medical terminology used in this Contract that have meanings unique to health care. If there is a conflict between the terms of this Contract and commonly used terms, the terms of this Contract will govern. The words and phrases used in this Contract are defined in Section 11.

SECTION 2—ELIGIBILITY

2.1 Subscriber

You are eligible for coverage as a Subscriber under this Contract if:

a. You meet the Eligibility requirements of HAP and your Group; and

b. You live or work in HAP's Service Area.

2.2 Dependents

The following persons are eligible for coverage as the Subscriber's Dependents under this Contract if they meet the Eligibility requirements of HAP and the Group:

a. The Subscriber's legally married spouse.

b. The Subscriber's children, by birth or legal adoption who are under the age of 26.

c. The children of the Subscriber's spouse, by birth or legal adoption who are under the age of 26.

d. A Subscriber's child who is recognized under a Qualified Medical Child Support Order. A copy of the court order or divorce decree is required to enroll the child.

If this Contract is considered a grandfathered plan as defined in the Affordable Care Act (ACA), adult children of the Subscriber or the Subscriber's spouse are not eligible as a Dependent under this Contract if the adult child is eligible to enroll in an eligible employer-sponsored group health plan other than a group health plan of a parent. This restriction only applies to Benefit Periods beginning before January 1, 2014.

2.3 Coverage Period for a Dependent Child

a. A child born to a Subscriber or Subscriber's spouse is automatically eligible to become insured as a Dependent. The Effective Date of Coverage will be the date of birth. Coverage will be to the same extent as provided for other Dependent children. Such coverage includes Covered Services for:

   1) Diagnosed Congenital Defects.

   2) Birth abnormalities.

   3) Prematurity.

   4) Routine nursery care.

   5) Routine well-baby care while hospitalized.

b. Eligibility for coverage for a child by legal adoption begins on the day of placement for adoption. Placement means the day on which the Subscriber or the Subscriber's spouse assumes and retains the legal obligation for total or partial support of the child in anticipation of adoption of the child.

c. Eligibility for coverage for a child who is your Dependent ends on the earliest of the following:

   1) The last day of the calendar year in which the child reaches the age of 26, or

   2) The date the child becomes eligible for an employer-sponsored group health plan other than a group health plan of a parent. This only applies to Benefit Periods beginning before January 1, 2014.

d. Eligibility for coverage for a child who is your Dependent continues without limitation if the child is diagnosed as permanently disabled due to a physical or mental condition that initially occurred and was documented before the child reached the age of 26, and the child relies on you for all or most of their support. Satisfactory proof of the permanent disability must be presented to HAP no later than 31 days after your Dependent attains age 26.

e. Eligibility for coverage for a child under a Qualified Medical Child Support Order begins on the date of the court order, if HAP receives notice within 30 days of the court order. If HAP receives notice longer than 30 days after the court order is issued, coverage is effective on the date HAP receives the notice. If the Subscriber who is under the court order does not enroll the child, the other parent or the State child support enforcement agency may apply. Coverage continues for as long as the court order is in effect or until the child no longer meets HAP's Eligibility requirements, whichever is earlier.

f. Coverage for Students Away at School

1) **If a Dependent does not live with the Subscriber because he or she is attending school full time, the following services are covered:**

a) Emergency care, Urgent Care or acute care.

b) Follow-up office visit related to acute Illness or Injury **only** with the pre-approval of HAP's Managed Care Coordinator or Associate Medical Director.

c) X-rays provided in the outpatient setting and related to the acute Illness or acute Injury.

d) Laboratory tests provided in the outpatient setting and related to the acute Illness or acute Injury.

e) Hepatitis B and allergy injections.

f) Physical therapy for rehabilitation beyond the first and second follow-up appointments relate to an acute Illness or acute Injury, only with advance approval from HAP's Medical Director or designee.

g) Durable Medical Equipment related to an acute Illness or acute Injury, when ordered or arranged for through HAP. HAP reserves the right to pay maximally only the usual, customary and reasonable (fee schedule) rates within HAP's service area for such items. This only applies if this Contract includes a Rider that adds coverage for Durable Medical Equipment.

h) Medication related to an acute Illness or acute Injury is a covered benefit provided the Dependent has a Prescription Drug Rider.

i) Conditions identified as requiring immediate follow-up services.

j) In the event of an Inpatient emergency admission, HAP Admission Department must be notified within 48 hours. HAP reserves the right to transfer a Dependent to an alternative facility if deemed necessary for continued care.

2) **The following services are not considered Urgent Care or an Emergency and will not be covered for students away at school:**

a) Routine complete physical examinations including gynecological exams.

b) Outpatient non-emergency psychiatric care and substance abuse care.

c) All elective surgery or hospitalizations.

d) Routine eye examinations and/or eyeglasses (optometry and optical services).

e) Obstetrical and gynecological services for pregnancy.

f) Sports medicine (i.e. muscle strengthening).

g) Physician visits, physical therapy, occupational therapy or other therapies or treatments that are not prior authorized by HAP.

h) Chronic dermatology including, but not limited to acne.

2.4 Effect of Medicare Eligibility

If you are eligible for Medicare, you may be eligible for coverage under this Contract only if you are an active employee, an eligible retiree or an eligible Dependent as defined by your Group and your Group purchases the Complementary/Wrap Medicare Rider. You must be enrolled in Medicare Parts A and/or B.

2.5 Initial Enrollment

You and your Dependents must enroll for coverage under this Contract within 31 days of becoming eligible or, in the case of an Open Enrollment period, within the period specified by your Group or Remitting Agent. If you fail to do so, you and/or your Dependents will not be permitted to enroll until the next Open Enrollment period.

2.6 Changes in Eligibility

You must notify your Group or Remitting Agent of events that might change the Eligibility of you and your Dependents for coverage under this Contract. These events include birth, adoption, marriage, divorce, death or a mid-year loss of other health coverage. We must receive notice of these events from your Group or Remitting Agent within 31 days of the event in order to provide coverage and/or adjust Premiums. We will only cover new Dependents upon timely payment of any additional Premium due to HAP.

2.7 Notifying HAP of Important Changes

You must notify HAP as soon as possible, but at least within 31 days, of any of the following changes for either you or your Dependent:

a. A change in your name, address or telephone number.

b. Retirement or other changes in your employment status.

c. A change in Medicare eligibility or coverage such as entitlement to, enrollment in or disenrollment from Medicare Parts A and/or B.

d. The addition of, or a change in, any other health coverage to which you or your Dependent may be entitled.

2.8 Failure to Notify HAP of Changes

Failure to provide timely and complete notice of changes in Eligibility or other important changes as noted above may result in a lapse in coverage and a denial of claims. HAP is not responsible

for a lapse in coverage when you, your Group or Remitting Agent do not notify HAP of these changes.

2.9 Documentation for Coverage

Upon request by us, you must give us information, including copies of documents, which help us determine the Eligibility of you or your Dependents for coverage under this Contract.

SECTION 3—PAYMENT OF PREMIUMS AND COPAYMENTS

3.1 Payment of Premium

All Premiums are due and payable in advance. The first Premium must be paid before coverage becomes effective. Thereafter, Premium must be paid on or before the Premium Due Date. If Premiums are not paid when due, the Contract will end.

3.2 Grace Period

A grace period of 30 days will be granted for the payment of each Premium falling due after the first Premium, during which grace period the Contract will continue in force, subject to our right to cancel in accordance with Section 8.3 of this Contract.

3.3 Agreement to Pay for Services if Premium is Not Paid

You are not entitled to Covered Services during any period for which a Premium was due but not paid by your Group or Remitting Agent. If you receive Covered Services during such a period, you are responsible for paying the provider for those services or reimbursing us in the event that we paid for such services.

3.4 Change in Premiums

HAP may change the Premiums as of any Premium Due Date by giving written notice to your Group or Remitting Agent at least 30 days prior to the effective date of such change.

3.5 Premium Refund

If the a Member dies while this Contract is in force, HAP will refund the Premium paid from the date following the date of death to the end of the period for which Premium has been paid. The Premium refund will be issued to the Group, Remitting Agent or Subscriber who paid the Premium.

3.6 Copayment and Out-of-Pocket Expenses

You are responsible for paying any Copayment, Coinsurance, Deductible, Out-of-Pocket Maximum and any other cost-sharing amounts for Covered Services established in all applicable Riders and the Schedule of Benefits. You are also responsible for all costs associated with services that are not Covered Services as defined under this Contract.

SECTION 4—SERVICES AND BENEFITS

The services and benefits described in this Section are Covered Services when provided in accordance with HAP's benefit, referral and practice policies by an Affiliated Provider, or as otherwise approved by HAP or its designee. Only services that are Preventive Services and/or Medically Necessary and approved by HAP or its designee are Covered Services under this Contract. These services have limitations and exclusions that are outlined in this Section and in Section 5.

4.1 Inpatient Hospital Care

HAP provides coverage for Inpatient hospital days and related hospital services that have been approved by HAP when you or your representative notifies HAP within 48 hours of your Inpatient hospital admission, and when the services are provided by a HAP Affiliated Hospital, including but not limited to:

a. Semi-private room and board, including meals and special diets.
b. Regular nursing services.
c. Special care units, such as intensive or coronary care units.
d. Operating, recovery and other treatment rooms.
e. Diagnostic laboratory tests, X-rays and pathology services.
f. Prescription drugs and medications.
g. Administration of blood, blood plasma and other biologicals.
h. Medical supplies and equipment, including oxygen.
i. Anesthetics and anesthesia services.
j. Rehabilitation services (e.g., physical, occupational and/or speech therapy).
k. Radiation therapy.
l. Inhalation therapy.

4.2 Outpatient Hospital Care

HAP covers outpatient hospital services provided by a HAP Affiliated Hospital, including but not limited to:

a. Pre-surgical testing.
b. Dressings, casts, and sterile tray services.
c. Operating, recovery, and other treatment rooms.
d. Diagnostic laboratory tests, X-rays and pathology services.
e. Prescription drugs and medications.
f. Administration of blood, blood plasma and other biologicals.
g. Medical supplies and equipment, including oxygen.
h. Anesthetics and anesthesia services.
i. Radiation therapy.

4.3 Professional Services of Physicians

HAP covers the professional services of physicians who are Affiliated Providers as follows:

a. In the physician's office, outpatient section of a Hospital or other outpatient clinic or medical center.

b. During an Inpatient Hospital stay.

c. In a skilled nursing facility.

4.4 Preventive Services

Preventive services are those services necessary to help avoid the development of disease processes, as defined by the Affordable Care Act (ACA), in accordance with the limitations in cost sharing pursuant to ACA. Preventive services are listed in HAP's Preventive Services Reference Guide which is available on our website **www.hap.org/preventive services** or you may request a copy by contacting our Client Services department at (313) 872-8100 or (800) 422-4641.

Preventive services are covered when provided by a HAP Affiliated Provider and include the following services:

a. Immunizations (doses, recommended ages and recommended populations vary)

1) Certain Vaccines – children from birth to age 18

2) Certain Vaccines – all adults

b. Certain drugs

1) Aspirin – use for men and women of certain ages

2) Folic Acid Supplements – women who may become pregnant

3) Fluoride Chemoprevention Supplements – children without fluoride in their water source

4) Gonorrhea Preventive Medication – all newborns

5) Iron Supplements – children age 6 to 12 months at risk for anemia

c. Screening and Counseling Services for Adults

1) Abdominal Aortic Aneurysm – for men of specified ages who have ever smoked (one time screening only)

2) Alcohol Misuse Screening and Counseling – all adults

3) Blood Pressure Screening – all adults

4) Cholesterol Screening – adults of certain ages or adults at higher risk

5) Colorectal Cancer Screening – adults over age 50

6) Depression Screening – all adults

7) Type 2 Diabetes Screening – all adults

8) Diet Counseling – all adults

9) HIV Screening – all adults

10) Obesity Screening and Counseling – all adults

11) Sexually Transmitted Infection (STI) Prevention Counseling – all adults

12) Tobacco Use Screening – all adults (includes cessation interventions for tobacco users)

13) BRCA Counseling and Genetic Testing – all adults at higher risk

d. Screening and Counseling Services for Women Only (Including Pregnant Women)

1) Anemia Screening – on a routine basis for pregnant women

2) Bacteriuria (urinary tract or other infection) Screening – pregnant women

3) Breast Cancer Mammography Screenings – every 1 to 2 years for women over age 40

4) Breast Cancer Chemoprevention Counseling – women at higher risk

5) Breastfeeding – comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women

6) Cervical Cancer Screening

7) Domestic and Interpersonal Violence Screening and Counseling – all women

8) Gestational Diabetes Screening

9) Hepatitis B Screening – pregnant women at their first prenatal visit

10) Human Papillomavirus (HPV) Genetic Testing – women beginning at age 30

11) Osteoporosis Screening – women over age 60 depending on risk factors

12) Rh Incompatibility Screening – all pregnant women and follow-up testing for women at higher risk

13) Tobacco Use Screening – expanded counseling for pregnant tobacco users

14) Well-Women Visits

15) Women's Prescribed Contraception Methods – Food and Drug Administration approved contraceptive methods, sterilization procedures, and education and counseling, subject to the following exclusions and limitations:

a) No coverage is provided under Preventive Services or under any Prescription Drug Rider for Members of a plan established or maintained by a religious employer certified as exempt from providing such coverage under the ACA.

b) No coverage is provided under Preventive Services or under any Prescription Drug Rider for Members of a plan established or maintained by an organization certified as a non-profit religious organization under the provisions of the ACA.

c) Brand name contraceptive drugs are only covered under Preventive Services if approved by HAP as Medically Necessary. If your plan includes a Prescription Drug Rider, brand name contraceptive drugs are covered at the Copayment and/or Deductible described in your Prescription Drug Rider. The Copayment and/or Deductible may be waived for brand name contraceptive drugs if there are no appropriate generic products or formulary alternatives available. An Affiliated Provider must first certify to HAP and HAP must agree that the available generic and formulary alternatives are ineffective or pose unnecessary risk to you. In such instances, the Copayment and/or Deductible are waived only if the covered contraceptive is dispensed by an Affiliated Provider pharmacy and the request for coverage is approved by HAP.

If you elect to receive a brand name contraceptive drug when an equivalent generic contraceptive drug is available, you will be responsible for the difference in the cost between the generic and brand name contraceptive drug in addition to the Copayment and/or Deductible. All other terms and conditions of the Prescription Drug Rider apply.

d) If you are not covered under any plan providing Prescription Drug benefits, brand name contraceptives are only covered under Preventive Services when an Affiliated Provider certifies to HAP and HAP agrees that the available generic and formulary alternatives are ineffective or pose unnecessary risk to you.

e) No coverage is provided for abortifacient drugs.

e. Assessments and Screenings for Children

1) Routine well child visits including physical and developmental screenings and assessments – all children at age appropriate intervals

2) Alcohol and Drug Use Assessments – adolescents

3) Cervical Dysplasia – sexually active females

4) Depression Screening – adolescents

5) Dyslipidemia Screening – children at higher risk for lipid disorders

6) HIV Screening – adolescents at higher risk

7) Sexually Transmitted Infection (STI) Prevention Counseling and Screening – adolescents at higher risk

Eligible preventive services are determined by recommendations and comprehensive guidelines of governmental committees and organizations which may be updated to reflect new scientific and medical advances. For a comprehensive list of recommended preventive services, please visit **www.healthcare.gov/center/regulations/prevention.html**.

You are responsible for any cost-sharing associated with preventive services received if the primary purpose of the office visit was not the delivery of preventive services. If this Contract is considered a grandfathered plan as defined in the ACA, cost-sharing may be required for all preventive services including contraceptive drugs as indicated in the Schedule of Benefits or an attached Rider.

4.5 Diabetic Care

The following services for diabetic Members are covered when ordered, arranged and provided by a HAP Affiliated Provider:

a. Blood glucose monitors, insulin infusion pumps and supplies according to quantity and other limitations.

b. Sessions with a certified diabetes educator, registered nurse, or dietitian for the purpose of working with the diabetic patient through diet and self-management training to maintain glucose control and optimize medical management of the disease.

4.6 Gynecological and Maternity Care Services

a. Female HAP Members may receive routine obstetric and gynecological ("OB/GYN") care such as yearly pelvic exams, pap smears and screening mammograms from any HAP Affiliated OB/GYN Provider regardless of Physician Network or Medical Group assignment. Non-routine OB/GYN care must be provided by an Affiliated OB/GYN Provider within the Member's assigned Physician Network or Medical Group, unless otherwise authorized by HAP or its designee.

HAP recommends that a woman preparing for childbirth select an obstetrician in her assigned Physician Network or Medical Group for prenatal care. This will help ensure delivery at her Physician Network or Medical Group Affiliated Hospital.

b. Maternity care includes prenatal, Inpatient Hospital and postpartum services provided to the mother by a HAP Affiliated Provider, including an Affiliated midwife.

c. HAP provides coverage for Inpatient hospital services in connection with childbirth for the mother and newborn child for up to 48 hours for a vaginal delivery and 96 hours following a delivery by cesarean section.

4.7 Weight Loss Programs and Services

If HAP's guidelines are met, the following weight loss services are covered when ordered and arranged for by a HAP Affiliated Provider and approved by HAP or its designee:

a. Weight loss programs conducted by a HAP Affiliated Provider, limited to one program per lifetime. Programs are covered for a period not to exceed 12 consecutive months.

b. Bariatric surgery performed at a facility approved by HAP with a $1,000 Copayment. Services must be Medically Necessary according to HAP's benefit, referral and practice policies.

4.8 Ambulance Services

a. An ambulance is a vehicle specially equipped and licensed for transporting wounded, injured, or sick persons and for providing limited medical services during such transport.

b. Ambulance services provided in an Emergency are Covered Services under any of the following situations:

1) When you receive Emergency services as described in Section 4.9.

2) When the ambulance is ordered by an employer, or a school, fire, or public safety official, and you are not in a position to refuse treatment.

4.9 Emergency Services

We cover Emergency Services whether received within or outside of the HAP Service Area subject to the limitations of this Section.

a. Emergency services are services provided to diagnose, treat and stabilize an Emergency Medical Condition. Emergency services end when your Emergency Medical Condition is stabilized.

b. If you are admitted to the Hospital as an Inpatient for an Emergency Medical Condition, you or your representative must notify HAP within 48 hours of the Hospital admission. If notice is not given to HAP within 48 hours, the Inpatient Hospital services will not be covered, unless your medical condition prevented you from notifying HAP or instructing your representative to notify HAP. If you are conscious and able to communicate with others, you are considered to be capable of notifying HAP. In the case of a minor child, the Subscriber is responsible for notifying HAP.

4.10 Services After an Emergency

a. You should contact your PCP after an Emergency is stabilized so that your PCP may provide or arrange for any necessary follow-up care. Follow-up care received from any

provider is not covered unless provided or arranged by your PCP and, if necessary, approved in advance by us.

b. If, during or following an Emergency, you are admitted to a hospital that is not a HAP Affiliated Hospital, or to an Affiliated Hospital outside your assigned Physician Network or Medical Group, we may transfer you to a HAP Affiliated Hospital within your assigned Physician Network or Medical Group. We may transfer you when the transfer can be safely provided and would not jeopardize your medical condition, in the judgment of the attending physician and HAP or its designee. Covered Services will be extended until a transfer can be safely provided or until discharge, whichever occurs first. In the event of a transfer, the cost of appropriate transportation is a Covered Service.

c. If you, or a representative on your behalf, refuse a transfer that HAP and the attending provider have deemed appropriate, we will not cover continued care at the initial facility; rather, you will be solely responsible for the costs of any services rendered after refusing the transfer.

4.11 Urgent Care Services

a. In the event that you need Urgent Care while you are in the Service Area, you should contact your PCP or seek services from an Affiliated urgent care center. Covered Services also include Medically Necessary services at any urgent care center if you are outside HAP's Service Area and are unable to return before receiving services. Coverage for Urgent Care is limited to Covered Services provided by your PCP or at an urgent care facility.

b. You must contact your PCP *after* receiving Urgent Care, so that your PCP may arrange or provide any necessary follow-up care. Follow-up care received from any provider is not covered unless provided or arranged by your PCP and, if necessary, approved in advance by us.

4.12 Mental Health Services

Coverage for Mental Disorders is limited to the most appropriate method and scope of treatment as approved by HAP or its designee. You must contact the HAP Coordinated Behavioral Health Management department directly at (800) 444-5755 for coordination of care for mental health services.

Services must be provided by the following Affiliated Providers:

1) Licensed psychiatrist.
2) Master of Social Work with certification.
3) Clinical nurse specialist.
4) Licensed psychologist.
5) Accredited mental health clinic.
6) Licensed residential treatment center.
7) A Hospital which provides mental health services.

a. **Inpatient Mental Health Services**

This level of care provides high intensity medical and nursing services in a structured environment providing 24-hour skilled nursing and medical care for an acute short term

mental health condition or acute aggravation of an ongoing condition. Charges may include:

1) Semi-private room and board.

2) Hospital or facility based professional charges.

3) Attending Physician charges.

4) Partial programs which may include day treatment.

5) Medical services and supplies.

b. **23-Hour Observation**

A period of observation for up to 23 hours when services provided are less than acute level of care. Indicated for situations where full criteria for Inpatient hospitalization are not met. Observation allows additional time for information gathering or risk assessment.

c. **Mental Health Day Treatment Services**

Intensive day treatment programs may be covered in lieu of inpatient mental health services. Intensive, non-residential level of service, similar in intensity to Inpatient, meeting for more than four hours (and generally, less than eight hours) weekdays.

d. **Outpatient Mental Health Services**

Covered outpatient mental health services may include psychiatric consultations and diagnosis and the use of other psychotherapeutic services as identified in a treatment plan approved by HAP or its designee. These visits must be provided by an appropriate Affiliated Provider who is a licensed behavioral health professional. The least intensive level of service, typically provided in an office setting for individuals or groups with limited identified time limits from 20-50 minutes (for individuals) and to 90 minutes (for group therapies) per day. Charges may include:

1) Evaluation and diagnostic services.

2) Therapeutic services including psychiatric services.

3) Brief intervention and counseling services.

4) Treatment for a Dependent including family therapy.

5) Group therapy sessions.

6) Medication reviews.

e. **Intensive Outpatient Mental Health Treatment Services**

Multidisciplinary, structured services provided at a greater frequency and intensity than outpatient treatment generally three hours per day, up to five days per week. Treatment modalities include individual, family, group and medication therapies.

4.13 Chemical Dependency Services

Coverage for treatment of Chemical Dependency is limited to the most appropriate method and level of treatment necessary as approved by HAP or its designee. Coverage for outpatient services for Chemical Dependency treatment will not be less than the minimum benefit established by the State of Michigan, Department of Insurance and Financial Services. You must contact the HAP Coordinated Behavioral Health Management department directly at (800) 444-5755 for coordination of care for chemical dependency services.